1195

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01172

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Carvel Beach
LENGTH OF STAY (in this place) X
HOSPITAL OR INSTITUTION OR STREET ADDRESS Carvel Beach Road X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Carvel Beach X
STREET ADDRESS (If rural give location) Carvel Beach Road

3. NAME OF DECEASED: (Type or Print) (First) WILLIS (Middle) MONROE (Last) ALEXANDER

4. DATE OF DEATH: (Month) Feb. (Day) 7 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Dec. 20, 1895

9. AGE last birthday: 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Portable Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Brooklyn Corp.

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin W. Alexander

14. MOTHER'S MAIDEN NAME: Alethia Spurrell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY No.: 215-16-2591

17. INFORMANT & ADDRESS: Bertha Alexander, Carvel Beach, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) CORONARY THROMBOSIS — Interval Between Onset And Death: IMMEDIATE

DUE TO

Antecedent causes (b) Arteriosclerotic Cardio Vascular Renal — 5 years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JUNE, 1949, to Feb. 7, 1954, that I last saw the deceased alive on 2/11, 1954, and that death occurred at 10:05 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
J. Brady Smith M.D. Riviera Beach, Md. 2/7/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 2/10/54 NAME OF CEMETERY Moreland Memorial Pk LOCATION (City, town, or county) Parkville, (State) Maryland

DATE REC'D BY LOCAL REGISTRAR 2-8-54 REGISTRAR'S SIGNATURE A W Burdette

24. FUNERAL DIRECTOR Wm. Cook, Inc., ADDRESS 1217 St. Paul St.

VS

Item 12,13,14 film G 161 3/3/54 cm

1196

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01173

CERTIFICATE OF DEATH

Reg. Dist. No. 25

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY A.A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Rock View Beach
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bay Harbor
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) MR. (Middle) JOHN (Last) ANTHONY

4. DATE OF DEATH: (Month) 2 (Day) 21 (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	W	1/6/86	68 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Steam Fitter	Own	England.	USA

13. FATHER'S NAME: Richard unknown

14. MOTHER'S MAIDEN NAME: Dorothy unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No		Family - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
420.1 Immediate cause	(a) CEREBRAL HEMORRHAGE	4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) CORONARY THROMBOSIS	3 weeks
	DUE TO (c) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE	5 years

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from JAN 24 19 54, to FEB 21, 19 54, that I last saw the deceased alive on FEB 21, 1954, and that death occurred at 1:45 P. m., from the causes and on the date stated above.

SIGNATURE J. Brady Smith (DEGREE OR TITLE) M.D. ADDRESS Riviera Beach, Md. DATE SIGNED 2/22/54

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/24/54	Cath.	Balto.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
February 24, 1954	Ida M. Whitman	Agnes L. McCleary	130 E. Fort Ave

RECEIVED
FEB 25 1954
BUREAU V. S.

1197

01174

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 23 E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY P. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rock View / Beach
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bac Nac Boc
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) MRS. (Middle) MARGARET J. (Last) ANTHONY

4. DATE OF DEATH: (Month) 2 (Day) 21 (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F.	W	W	11/7/79	74 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housework	Home	Balto.	

13. FATHER'S NAME: Luke Williams

14. MOTHER'S MAIDEN NAME: Mary Foyler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No		Family - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause 422.1	(a) Degenerative Cardio Vascular Disease	5 years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Arteriosclerotic Cardio Vascular Disease DUE TO	7 years
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1953, to Feb. 21, 1954, that I last saw the deceased alive on Feb. 21, 1954, and that death occurred at 7:45 P. m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
J. Brady Smith	M.D.	Riviera Beach, Md.	2/22/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/24/54	STL	Balto	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
February 24, 1954	Ida M. Whitson	Jos. L. McCarey	130 E. Fort Ave.

RECEIVED
FEB 25 1954
BUREAU V. S.

1179

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01175

Reg. Dist. No. 21

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis Md
LENGTH OF STAY (in this place) 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A A
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 10
STREET ADDRESS (If rural give location) 518 Burnside Ave

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Joseph (Last) Benda

4. DATE OF DEATH: (Month) 2 (Day) 15 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: Apr. 14th 1884
9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Tailor
10b. KIND OF BUSINESS OR INDUSTRY: Tailor
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? N. S. A.

13. FATHER'S NAME: James Benda
14. MOTHER'S MAIDEN NAME: Barbara Cihler

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: —
17. INFORMANT & ADDRESS: Veronica Benda 518 Burnside Ave Annapolis Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

Immediate cause (a) Arterio Sclerotic Heart — Interval Between Onset And Death: Several years

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Disease

DUE TO (c) Generalized Arterio Sclerosis — Several years

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chr. Cystitis — Several years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1952, to Feb 15, 1954, that I last saw the deceased alive on Feb 15, 1954, and that death occurred at 10 AM from the causes and on the date stated above.

SIGNATURE George C. Basil (Degree or title) M. D. ADDRESS Annapolis Md DATE SIGNED 2.16.54

23. BURIAL, ~~CREMATION, REMOVAL~~ (Specify) DATE THEREOF ~~2-18-54~~ NAME OF CEMETERY OR CREMATORY St Marys LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REGISTRAR Feb. 17, 1954 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor Sons ADDRESS Annapolis Md

RECEIVED
FEB 26 1954
BUREAU V. S.

Item 8 film G 164 4/12/54 emf

1198

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 61176
No. .....

1. PLACE OF DEATH:
COUNTY A A MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lothian
LENGTH OF STAY (in this place) 8 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY A A
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Lothian
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Nettie (Middle) (Last) Blake

4. DATE OF DEATH (Month) 2 (Day) 27 (Year) 1954

5. SEX: F
6. COLOR OR RACE: C.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: July 15 1891/1891
9. AGE last birthday: 69 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Bristol
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Franklin
14. MOTHER'S MAIDEN NAME: Susie Franklin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: —
17. INFORMANT & ADDRESS: Lucille Easton, Tracy, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.0
Immediate cause (a) Myocardial Infarction
DUE TO
Antecedent cause(s) (b) Arteriosclerotic Heart Disease
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.,
21c. (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Boyce Linn Grant M.D.
M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒
DATE SIGNED 2-27-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 3/2/54
NAME OF CEMETERY OR CREMATORY Moses
LOCATION (City, town, or county) (State) Drury Md

DATE REC'D BY LOCAL REG. 2/28/54
REGISTRAR'S SIGNATURE Eleanor Williams
24. FUNERAL DIRECTOR T A Hardesty & Son, ADDRESS Galesville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15A - 5 - 53

RECEIVED
MAR -4 1954
BUREAU V. S.

1199

MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 78

01177

M

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville X
LENGTH OF STAY (in this place) 2 yrs. 2 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4
STREET ADDRESS (If rural, give location) 2221 division Street ✓✓

3. NAME OF DECEASED (Type or Print) (First) Paul (Middle) (Last) Bradham

4. DATE OF DEATH (Month) 2 (Day) 1 (Year) 1954

5. SEX Male

6. COLOR OR RACE Negroid

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH 1867?

9. AGE last birthday 86? yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown

10b. KIND OF BUSINESS OR INDUSTRY Unknown

11. BIRTHPLACE (State or foreign country) South Carolina

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk. (If year, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis

(c)

INTERVAL BETWEEN ONSET AND DEATH

Known to us since adm. 11/28/51

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/1/, 1953, to 2/1, 1954, that I last saw the deceased alive on 2/1, 1954 and that death occurred at 4:40 p.m. from the causes and on the date stated above.

SIGNATURE (Degree or title) Arnold N. Eichert, M.D.

ADDRESS Crownsville, Md.

DATE SIGNED 2/1/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE 2/5/54

NAME OF CEMETERY OR CREMATORY Laurel Cemetery

LOCATION (City, town, or county) Balto. Md. (State)

DATE REC'D BY LOCAL REG. 2/5/54

REGISTRAR'S SIGNATURE A. W. Hedrick

24. FUNERAL DIRECTOR Charles G. Cooper

ADDRESS 512 Cambleton Ave

1200

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

01178

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 2 6

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN P.O. Linthicum
LENGTH OF STAY (in this place) 9 y.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Maple Dale Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Same COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same
STREET ADDRESS (If rural, give location) Same

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) August Otto Brauer

4. DATE OF DEATH (Month) (Day) (Year) Feb. 9th. 1954 19

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH 5/18/89

9. AGE last birthday 64 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Germany, Europe.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 216-01-8377

17. INFORMANT AND ADDRESS Mr. Helmuth Brauer, Linthicum, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection* X, *Inquiry* X *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE Gustave W. Fauchet Md. (Degree or title) Deputy Medical Examiner. ADDRESS Glen Burnie Md. DATE SIGNED 2/10/54

DISPOSITION (Specify) Burial

DATE THEREOF 2/12/54

NAME OF CEMETERY OR CREMATORY Holy Cross

LOCATION (City, town, or county) (State) Ritchie Hgwy

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR JOHN F. DENNY, INC. ADDRESS 715 Light St.

1180

Dr. Walker

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01180

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Calvert
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick
STREET ADDRESS (If rural give location) - - -

3. NAME OF DECEASED: (Type or Print) (First) PAUL (Middle) (Last) BUCKLER

4. DATE OF DEATH: (Month) FEBRUARY (Day) 7, (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: December 23, 1948
9. AGE last birthday: 5 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert Buckler
14. MOTHER'S MAIDEN NAME: Virginia Hardesty

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) - - (If Yes, give war or dates of service) - -
16. SOCIAL SECURITY No.: - - -
17. INFORMANT & ADDRESS: Mr. Albert Buckler, Prince Frederick, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

092X

Immediate cause (a) Hepatitis, infectious

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

Interval Between Onset And Death 1 month

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6 Feb, 1954, to 7 Feb, 1954, that I last saw the deceased alive on 7 Feb, 1954, and that death occurred at 7:25 A.M., from the causes and on the date stated above.

SIGNATURE Steve D. Walker (Degree or title) ADDRESS Carvel Hall, Annapolis Md. DATE SIGNED 7 Feb 54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Feb. 9, 1954
NAME OF CEMETERY OR CREMATORY Mt. Harmony Cemetery
LOCATION (City, town, or county) (State) Mt. Harmony, Md
DATE REC'D BY LOCAL REGISTRAR Feb. 8, 1954
REGISTRAR'S SIGNATURE Grace L. Hutchins
24. FUNERAL DIRECTOR Wm. H. Hutchins, Owings, Md
ADDRESS

Wm J. French mmb.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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1181

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21 — 1181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A.A. County MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crumpton Md; LENGTH OF STAY 3 Days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Baltimore Gen Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE A.A COUNTY; CITY OR TOWN GLEN BURNIE X; STREET ADDRESS (If rural give location) 215-4TH AVE. S.W

3. NAME OF DECEASED (Type or Print): (First) CARLANA (Middle) S. (Last) BUNTING

4. DATE OF DEATH: (Month) 2 (Day) 11 (Year) 1954

5. SEX: M | 6. COLOR OR RACE: WHT | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED | 8. DATE OF BIRTH: JAN 12 1897 | 9. AGE last birthday: 57 yrs. | IF UNDER 1 YEAR: Months Days 11 30 | IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: ELECTRICIAN | 10b. KIND OF BUSINESS OR INDUSTRY: GREIF + CO | 11. BIRTHPLACE (State or foreign country): GLOUCESTER Co VA | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: SAMUEL BUNTING

14. MOTHER'S MAIDEN NAME: ELIZABETH GIVLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: TEKLA BUNTING-215-4TH AVE. S.W

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
416X Immediate cause	(a) Pulmonary Embolism & Infarction	1 hr
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Kidney Embolism & Infarction	4 mos
	DUE TO (c) Rheumatic Heart Disease	40 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	—	

19a. DATE OF OPERATION: — | 19b. MAJOR FINDINGS OF OPERATION — | 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — | (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/9/, 1954, to 2/11/, 1954, that I last saw the deceased alive on 2/11/, 1954, and that death occurred at 10 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Frank M Shirley MD | ADDRESS Annapolis Md | DATE SIGNED 2/11/54

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | DATE THEREOF 2/13/54 | NAME OF CEMETERY OR CREMATORY LOUDON PARK | LOCATION (City, town, or county) (State) I-REA AVE

DATE REC'D BY LOCAL REGISTRAR Feb 12, 1954 | REGISTRAR'S SIGNATURE C.W. Hedrick | 24. FUNERAL DIRECTOR GEO LEIMBACH | ADDRESS 525 N LYNDHURST ST

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01182

Reg. Dist. No. [redacted]

1. PLACE OF DEATH: COUNTY A.A. Calvert — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fair Haven — LENGTH OF STAY (In this place) 9 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) annie (Middle) louisa (Last) S. Burns

4. DATE OF DEATH: (Month) Feb (Day) 26 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): (Widowed)

8. DATE OF BIRTH: 16 Feb 1870

9. AGE last birthday: 84 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): England.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: unknown Stepfather

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no

16. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 578-03-4185

17. INFORMANT AND ADDRESS: F.V. Ringgold, Fair Haven Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hypertensive cardio-vascular renal disease. — Interval between onset and death:

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last: (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: None

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/8, 1953, to 2/26, 1954, that I last saw the deceased alive on 2/26, 1954, and that death occurred at 7:45 p.m., from the causes and on the date stated above.

SIGNATURE: H J Weems (Degree or title) MD ADDRESS Huntingtown Md. DATE SIGNED 2/26/54

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF: March 1, 1954 — NAME OF CEMETERY OR CREMATORY: Rock Creek — LOCATION (City, town, or county) (State): Washington D.C.

DATE REC'D BY LOCAL REG. Feb 26, 1954 — REGISTRAR'S SIGNATURE: Edward Collinson

24. FUNERAL DIRECTOR ADDRESS: Frances J Collins 14th Street N W Wash D C

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1202

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01183

CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:
COUNTY Anne arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harwood.
LENGTH OF STAY (in this place) all life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Calvert County -

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY a. a. co.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harwood. Md.
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Gladys (Middle) (Last) Chase

4. DATE OF DEATH: (Month) 2. (Day) 9. (Year) 1954.

5. SEX: female
6. COLOR OR RACE: negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: 1-7-54
9. AGE last birthday: ___ yrs. IF UNDER 1 YEAR Months 1 Days ___ IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): none.
10b. KIND OF BUSINESS OR INDUSTRY: none.
11. BIRTHPLACE (State or foreign country): Calvert County -
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Chase.
14. MOTHER'S MAIDEN NAME: Hazel Smith

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no
16. SOCIAL SECURITY NO.: no
17. INFORMANT & ADDRESS: John Smith, Harwood. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

490X

Immediate cause (a) Lobar pneumonia

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) malnutrition

DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: -
19b. MAJOR FINDINGS OF OPERATION -
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-9- ,1954, to 2-9. ,1954, that I last saw the deceased alive on 2-9 ,1954, and that death occurred at 4 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Emily H. Wilson, M.D.
ADDRESS Lattician, Md.
DATE SIGNED 2-9-54.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 2-11-54
NAME OF CEMETERY OR CREMATORY Patuxent Cemetery
LOCATION (City, town, or county) (State) Huntingtown Md
DATE REC'D BY LOCAL REGISTRAR 2-9-54
REGISTRAR'S SIGNATURE Elsie West Williams
24. FUNERAL DIRECTOR P.E. Sewell, Huntingtown Md.
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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84

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:
COUNTY A. A. Co. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover, R.F.D.
LENGTH OF STAY (in this place) 74 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Race Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY A. A. Co
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover, R.F.D.
STREET ADDRESS (If rural, give location) Race Rd.

3. NAME OF DECEASED: (Type or Print) (First) Samuel (Middle) S. (Last) Cook

4. DATE OF DEATH: (Month) (Day) (Year) Feb. 23rd 1954

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 9, 1879
9. AGE last birthday: 74 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor (retired)
10b. KIND OF BUSINESS OR INDUSTRY: Government
11. BIRTHPLACE (State or foreign country): A. A. Co. Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Abraham Cook
14. MOTHER'S MAIDEN NAME: Martha Eliza Briggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S ADDRESS: Mrs. Mabel Cook Hanover, R.F.D. #300

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

443X

Immediate cause (a) Hypertensive Cardio-Vas. Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

DUE TO

Antecedent cause(s) (b) Ac. Congestive Cardiac Failure — 1 Day

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1950 19 to 2/23/54 19, that I last saw the deceased alive on 2/22/54 19, and that death occurred at 12:10 a.m. from the causes and on the date stated above.

SIGNATURE Frank Shipley (DEGREE OR TITLE) M.D. ADDRESS Savage, Md. DATE SIGNED 2/23/54

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF 2-26-54
NAME OF CEMETERY OR CREMATORY St. Mark
LOCATION (City, town, or county) Dorsey Md. (State)
DATE REC'D BY LOCAL REG. 2-24-54
REGISTRAR'S SIGNATURE W. W. Hedrick
24. FUNERAL DIRECTOR Holland Funeral Home ADDRESS

VS. A15 8-

I MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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1203

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 81185

CERTIFICATE OF DEATH

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G. Meade, Md. X
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. ARMY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: Anne
STATE Maryland COUNTY Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton X
STREET ADDRESS (If rural give location) 41 Carvel Ave.

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) Philip (Last) Coyne

4. DATE OF DEATH: (Month) February (Day) 12 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: Cauc

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 10 February 1894

9. AGE last birthday: 56 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Engineering

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Civil Service

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: John Coyne

14. MOTHER'S MAIDEN NAME: Ellen Mellon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW I

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Robert Tucker Odenton, Md. (Son-in-Law)

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary Thrombosis

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from — ,19 —, to — , 19 —, that I last saw the deceased alive on — , 19 —, and that death occurred at 0920 hrs, from the causes and on the date stated above.

SIGNATURE Shelby M. Bayliss M.D. (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 16 Feb 54

NAME OF CEMETERY OR CREMATORY St. Matthew's Cemetery

LOCATION (City, town, or county) Conshohocken (State) Pa.

DATE REC'D BY LOCAL REGISTRAR 12 February 54

REGISTRAR'S SIGNATURE T. A. GORDON CWO USA

24. FUNERAL DIRECTOR Donaldson Funeral Home ADDRESS Laurel, Md.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01186

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G. Meade; LENGTH OF STAY (in this place) 1 yr; HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. ARMY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maine — COUNTY Cumberland; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN South Portland; STREET ADDRESS (If rural give location) Cedar Street

3. NAME OF DECEASED: (Type or Print) (First) Elva (Middle) Josephine (Last) Cronk

4. DATE OF DEATH: (Month) February (Day) 24 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced

8. DATE OF BIRTH: 2 October 1888

9. AGE last birthday: 65 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maine

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Samuel Jones

14. MOTHER'S MAIDEN NAME: Emma Hersey Pierce

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Norman H. Cronk (Son) 1924A Reece Rd, Ft GG Meade, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 170X Carcinoma of the breast with metastases to — Interval Between Onset And Death: 4 years

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) lungs, liver, lymph nodes, skin.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1950

19b. MAJOR FINDINGS OF OPERATION: Mastectomy, right, carcinoma of breast

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 26 Jan, 1954, to 24 Feb, 1954, that I last saw the deceased alive on 24 Feb 1954, and that death occurred at 6:50 pm, from the causes and on the date stated above.

SIGNATURE (Degree or title) Harvey D. Davis, MD — ADDRESS CAPT., MC 2101-1 ASU, USAH FT GG Meade, Md. — DATE SIGNED 25 Feb 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) Forrest City (State) Maine

DATE REC'D BY LOCAL REGISTRAR 1 March 1954 — REGISTRAR'S SIGNATURE T.A. GORDON, CWO, USA

24. FUNERAL DIRECTOR — ADDRESS WM. COOK, INC. BALTO., MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. The correct answer is especially important. Physicians: please write the causes of death clearly and accurately.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

C 1187

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

1. PLACE OF DEATH: COUNTY A. A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shadyside Md.
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shadyside
STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print): (First) Mitzell. (Middle) (Last) CROWNER.

4. DATE OF DEATH: (Month) 2 (Day) 6 (Year) 1954

5. SEX: M

6. COLOR OR RACE: Colored.

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)

8. DATE OF BIRTH

9. AGE Last birthday yrs. 6 | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Crowner

14. MOTHER'S MAIDEN NAME: Lenora S. Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT AND ADDRESS: George Crowner, Shadyside md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

754.4

Immediate cause (a) Congenital Heart disease

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ___ OR CONTRIBUTING ___ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ___, Inspection ✓, Inquiry ___ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE E. Lee Lacott (Degree or title) MD ADDRESS Annapolis Md DATE SIGNED 2/6/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 2/7/54 | NAME OF CEMETERY OR CREMATORY St Matthews | LOCATION (City, town, or county) (State) Shadyside md.

DATE REC'D BY LOCAL REG. 2-7-54 | REGISTRAR'S SIGNATURE Edwin Oliver Williams

24. FUNERAL DIRECTOR ADDRESS T A Hardesty & Son Lindenville. Md.

RECEIVED
FEB 9
BUREAU V. S.

11m6161-2/26/54 arb

1182

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~ Death

Reg. Dist. No. .....

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF STILLBIRTH
County: Anne Arundel Maryland.
City or town (If outside city or town limits write "RURAL" and nearest town): Annapolis
Street address, hospital, or institution: Johnson's Clinic
Length of mother's stay in this County (Give years, or months, or days): 27 yrs.

2. USUAL RESIDENCE OF MOTHER:
State: Maryland
County: Anne Arundel
City or town (If outside city or town limits write "RURAL" and nearest town): Annapolis
Street Address: 23 College Ave.

3. CHILD'S NAME (First) Linda (Middle) Dawson (Last)

4. Sex: Female
5. Twin or other: Single — If so-born 1st, 2nd, 3rd
6. DATE OF BIRTH (Month, Write Out) (Day) (Year): February 10 1954

FATHER OF CHILD
7. Full Name: Herbert Dawson
8. Color or race: Colored
9. Age at time of this birth: 33 yrs.
10. Birthplace (State or foreign country): North Carolina
11. Usual occupation: Air Force
Kind of industry or business:

MOTHER OF CHILD
12. Full maiden name: Florine Davis
13. Color or race: Colored
14. Age at time of this birth: 27 yrs.
15. Birthplace (State or foreign country): West River
16. Number of OTHER children born to mother (Do NOT include this child)

Now living	Born alive but now dead	Born dead	Total Children (Not including this child)
1	0	0	1

17. Length of pregnancy: 40 weeks
Weight of child at birth: 7 lbs. 8 oz.

18. CAUSE OF STILLBIRTH State only morbid conditions causing fetal death (do NOT use such terms as Stillbirth, Prematurity, Asphyxia, etc.)
(a) Fetal causes: Cardia Abnormality 754.4
(b) Maternal causes:

19. State any complications of pregnancy and labor: None
20. State all operations for delivery: None

Burial, Cremation, Removal, (Specify) Burial Date 2-13-54
Cemetery or Crematory: Brewer Hill
Location: Annapolis, Md
Funeral Director: William Reese, Jr.

21. I hereby certify that this child was born dead on the date stated above at ..... m
Signature: Theodore H. Johnson
Physician ☑ Midwife ☐ Other ☐
Address: 40 Northwest St
Date signed: 2-10-54

Date rec'd by local Reg.: Feb. 13, 1954
Registrar's signature: [illegible]
If NOT attended by Physician
"The above certificate has been examined by me"
Health Officer, per

NOTE: Midwives please take this certificate directly to the County Health Officer, or to your public health nurse for approval.

V.S. A10—8-51

Lived Few Hours

RECEIVED
MAR 1 1954
BUREAU V. S.

1207

MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1180

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum (Rural) — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum (Rural)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 208 Nursary Road	STREET ADDRESS (If rural, give location) 208 Nursary Road

3. NAME OF DECEASED (Type or Print)	(First) ANNIE	(Middle) BENSON	(Last) DeHOFF	4. DATE OF DEATH (Month) February (Day) 27, (Year) 1954
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH April 4, 1873	9. AGE last birthday 80 yrs. — If under 1 year: Months, Days — If under 24 hrs: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Forreston, Baltimore, Co.	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Benjamin F. Price, M.D.		14. MOTHER'S MAIDEN NAME Mary A. Harshberger		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS 208 Nursary Road Mrs. Mary L. Wellmer, Linthicum, Md.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443X

Immediate cause (a) Cerebral Hemorrhage

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Myocarditis.

(c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1953, to Feb, 1954, that I last saw the deceased alive on 2-24, 1954, and that death occurred at 9 15 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
[illegible]	M.D.	[illegible]	2-27-54

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE March 1, 1954.	NAME OF CEMETERY OR CREMATORY Mount Carmel	LOCATION (City, town, or county) (State) Baltimore County, Md.
DATE REC'D BY LOCAL REG. Feb 28, 1954	REGISTRAR'S SIGNATURE L. J. D'Alba	24. FUNERAL DIRECTOR T.W. Singleton,	ADDRESS Glen Burnie, Md.

Dr. Waldine A. Woodruff

MARGIN RESERVED FOR BINDING

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MAR 3

1208

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 0190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn
LENGTH OF STAY (in this place) 35 y.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Donaldson Avenue X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Same COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same X
STREET ADDRESS (If rural give location) Same

3. NAME OF DECEASED: (Type or Print) (First) Alexander (Middle) Edwards (Last)
4. DATE OF DEATH: (Month) Feb. (Day) 15 (Year) 1954
5. SEX: M.
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 12/4/89
9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Severn Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Granson Edwards
14. MOTHER'S MAIDEN NAME: Ada Harris
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No
16. SOCIAL SECURITY No.: No
17. INFORMANT & ADDRESS: William Edwards (Son.) Severn Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

410.X

Immediate cause (a) Mitral Insufficiency — Interval Between Onset And Death: I y.

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) General Arteriosclerosis — I y.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from February 53 to 2/15/54, 19..., that I last saw the deceased alive on 2/13/54 19..., and that death occurred at 5.55 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Gustave H. Fischer M.D. ADDRESS Glen Burnie, Md. DATE SIGNED 2/15/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Feb. 19, 1954
NAME OF CEMETERY OR CREMATORY Clark Station Cem
LOCATION (City, town, or county) Glen Burnie (State) Md.
DATE REC'D BY LOCAL REGISTRAR 2/17/54
REGISTRAR'S SIGNATURE [illegible]
24. FUNERAL DIRECTOR Mrs Katie R. Williams ADDRESS Schroeder St. 322 N

1183

1191

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) "
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. General

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY A A
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Riva
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) ROBERT (Middle) LOUIS (Last) FORTUNATO

4. DATE OF DEATH (Month) (Day) (Year) 2 - 6 - 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 1-15-1954

9. AGE last birthday: yrs. 52 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Annapolis Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Alexander Fortunato

14. MOTHER'S MAIDEN NAME: Irmalee Wells

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Alexander Fortunato Riva A A Co Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
Immediate cause	(a)	asphyxia	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b)		
	DUE TO (c)		

'762.0

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☑

DATE SIGNED 2/6/54

23. BURIAL, CREMATION, ~~REMOVAL~~ (Specify): DATE THEREOF 2/8/54 NAME OF CEMETERY OR CREMATORY Mt. Olivet LOCATION (City, town, or county) (State) Washington, D.C.

DATE REC'D BY LOCAL REG. Feb. 8, 1954 REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR John M. Taylor & Son ADDRESS Annapolis Md.

VS. A15A - 5 - 53

1209

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MARGIN RESERVED FOR BINDING

... INLY, WITH UNFADING INK. Supply every item of information carefully. The correct ... especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

01192

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN P.O. Pasadena
LENGTH OF STAY (In this place) 25 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hickory Point

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) August (Middle) M. (Last) FREITAG
4. DATE OF DEATH (Month) February (Day) 15 (Year) 1954
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 3/3/97
9. AGE last birthday 56 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Freitag
14. MOTHER'S MAIDEN NAME Margaret Lawrence
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 212-18-4166
17. INFORMANT AND ADDRESS Mrs. Sarah Freitag, Mo.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary Occlusion — Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy , Inspection X Inquiry X thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes X accident , suicide , homicide , undetermined .*

SIGNATURE (Degree or title) Gustave Paulsen M.D. ADDRESS Medical Examiner Glen Burnie Md. DATE SIGNED 2/15/54

FINAL CREMATION MOVAL (Specify) BURIAL
DATE THEREOF 2/17/54
NAME OF CEMETERY OR CREMATORY Glen Haven
LOCATION (City, town, or county) (State) Glen Burnie, Md

DATE REC'D BY LOCAL REG. 2/17/54
REGISTRAR'S SIGNATURE L. J. De Alba
24. FUNERAL DIRECTOR W. Kingston ADDRESS Glen Burnie, Md

BUREAU V. L.

1184

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01193

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Anne Arundel COUNTY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis 10
LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. Co. Gen'l. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: Anne Arundel
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Green Haven Pasadena P.O.
STREET ADDRESS (If rural give location) 7th Street

3. NAME OF DECEASED: (Type or Print) (First) Barbara (Middle) Ann (Last) Gearhart

4. DATE OF DEATH: (Month) February (Day) 17 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: Feb. 15, 1954
9. AGE last birthday: — yrs. IF UNDER 1 YEAR Months — Days 2 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Annapolis Md.
12. CITIZEN OF WHAT COUNTRY? —

13. FATHER'S NAME: Jack Gearhart
14. MOTHER'S MAIDEN NAME: Alice Grey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Jack Gearhart, Green Haven Pasadena P.O., Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

760.0

Immediate cause (a) Cerebral Hemorrhage DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 16, 1954, to Feb 17, 1954, that I last saw the deceased alive on Feb 17, 1954, and that death occurred at 6:30 PM, from the causes and on the date stated above.

SIGNATURE Edward G. Merritt (Degree or title) M.D. ADDRESS DATE SIGNED 2-18-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 2/18/54
NAME OF CEMETERY OR CREMATORY Glen Haven
LOCATION (City, town, or county) (State) Glen Burnie Md.
DATE REC'D BY LOCAL REGISTRAR 2/18/54
REGISTRAR'S SIGNATURE L. J. D'Alba
24. FUNERAL DIRECTOR R. V. Singleton ADDRESS Glen Burnie Md.

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BUREAU V. S.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A A — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 144 Charles St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md.
STREET ADDRESS (If rural, give location) 144 Charles St.

3. NAME OF DECEASED (Type or Print) (First) Naomi (Middle) Minnix (Last) Gerace
4. DATE OF DEATH (Month) 2 (Day) 12 (Year) 1954
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 2-11-1909
9. AGE last birthday 45 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trained Nurse
10b. KIND OF BUSINESS OR INDUSTRY Nursing
11. BIRTHPLACE (State or foreign country) Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Newton Minnix
14. MOTHER'S MAIDEN NAME Ada M. McGee
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS: Ada M. McGee 141 Charles St Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Disease — Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE [signature] (Degree or title) ADDRESS Annapolis Md — DATE SIGNED 2/12/54

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF 2-15-54 — NAME OF CEMETERY OR CREMATORY Cedar Hill — LOCATION (City, town, or county) Maryland (State) Md

DATE REC'D BY LOCAL REG. Feb. 15, 1954 — REGISTRAR'S SIGNATURE [signature] — 24. FUNERAL DIRECTOR John M Taylor Sons — ADDRESS Annapolis Md

RECEIVED
BUREAU V. S.

1185

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 94

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 239 Prince George St

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY A. A.
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 239 Prince George St.

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) RICHARD SOUTHALL GRANT

4. DATE OF DEATH (Month) FEB (Day) 6 (Year) 19 54

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Divorced	April 27-1895	58 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Photographer	Architectural	Annapolis Md.	U. S. A.

13. FATHER'S NAME: Albert W. Grant

14. MOTHER'S MAIDEN NAME: Florence E. Sharp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Miss Nell Preston Grant 564 W. 112th St New York City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Coronary disease — INTERVAL BETWEEN ONSET AND DEATH Sudden

420.1

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 2/6/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	2-11-1954	U. S. National Cem.	Annapolis Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Feb. 10, 1954	[signature]	John M. Taylor Son Annapolis Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01195

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garland Park (Glen Burnie P.O.) X
LENGTH OF STAY (in this place) 4 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 99 Elm Ave. X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garland Park X (Glen Burnie P.O.)
STREET ADDRESS (If rural give location) 99 Elm Ave.

3. NAME OF DECEASED: (Type or Print) (First) ROSINA (Middle) — (Last) GRUNWALT

4. DATE OF DEATH: (Month) 2 (Day) 12 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: March 6, 1866
9. AGE last birthday: 87 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Merzidorf, Hungary
12. CITIZEN OF WHAT COUNTRY? ?

13. FATHER'S NAME: John Regert
14. MOTHER'S MAIDEN NAME: ? Dietrick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Mrs. Marian Berwanger, 96 Packard Ave. Ferndale, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

Immediate cause (a) Cerebral Hemorrhage DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Hypertensive Heart Disease DUE TO

(c)

Interval Between Onset And Death 12 hrs

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1953, to 2-12, 1954, that I last saw the deceased alive on 2-12, 1954, and that death occurred at 5:10 P.M. from the causes and on the date stated above.

SIGNATURE C. B. MacDonald (Degree or title) Md. ADDRESS Glen Burnie, Md. DATE SIGNED 2-12-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF February 15, 1954
NAME OF CEMETERY OR CREMATORY Glen Haven
LOCATION (City, town, or county) (State) Glen Burnie, Md.
DATE REC'D BY LOCAL REGISTRAR 2/12/54
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR R. V. Singleton, ADDRESS Glen Burnie, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
COUNTY A.A. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Solley
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Solley Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY A.A.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Solley
STREET ADDRESS (If rural give location) Solley, Rd.

3. NAME OF DECEASED: (Type or Print) (First) Anna (Middle) F. (Last) Hall

4. DATE OF DEATH: (Month) 2 (Day) 18 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M.

8. DATE OF BIRTH: 6/8/1900

9. AGE last birthday: 53 yrs. IF UNDER 1 YEAR: Months | Days IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Balto.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frank Herbert

14. MOTHER'S MAIDEN NAME: Anna Yeski

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Family - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary heart disease

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Hypertension

DUE TO

(c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 15, 1952, to Feb 18, 1954, that I last saw the deceased alive on 2/17, 1954 and that death occurred at 3:30 P., from the causes and on the date stated above.

SIGNATURE (Degree or title) [signature] M.D.

ADDRESS Balfour Md. ~~Sally AA Co.~~

DATE SIGNED 2/19/54

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 2/22/54 | NAME OF CEMETERY OR CREMATORY Glen Haven | LOCATION (City, town, or county) Balto. (State)

DATE REC'D BY LOCAL REGISTRAR 2/19/54 | REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR [signature] ADDRESS 130 E. Fort Ave.

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M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]97

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Crownsville X
LENGTH OF STAY (in this place) 24 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2 USUAL RESIDENCE (HOME) OF DECEASED: Anne
STATE Maryland COUNTY Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, X
STREET ADDRESS (If rural give location) Crownsville P. Office R.D. 1

3. NAME OF DECEASED: (Type or Print) (First) MARIE (Middle) (Last) HALL
4. DATE OF DEATH: (Month) 2 (Day) 13 (Year) 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Negro	Married	Unknown ?	70 yrs.		

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	none	Maryland	U.S.A.

13. FATHER'S NAME: Robert Wilson
14. MOTHER'S MAIDEN NAME: Mariah Alexander

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
Unk -------	None	Hospital Records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

491X
Immediate cause (a) Bronchopneumonia (Terminal) — 48 hrs.
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) General Debility
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis Dry Gangrene of 2nd & 3rd Rt. toes.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/21, 1954, to 2/13, 1954, that I last saw the deceased alive on 2/13, 1954, and that death occurred at 4:55 P.m. from the causes and on the date stated above.

SIGNATURE (Degree or title) Arnold H. Eibert, M.D. — ADDRESS Crownsville State Hospital — DATE SIGNED 2/13/54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/16/1954	John Wesley Cemetery	Waterbury, A. A. Co. Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
~~Feb. 15, 1954~~ 2-17-54	H M Joe	Ethel L. Hicks-45 Northwest St. Annapolis Md.

VS. A15

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
COUNTY: A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 5411 Wasena Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn
STREET ADDRESS (If rural, give location): 5411 Wasena Ave

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last): Wilhelmina C. Harvey

4. DATE OF DEATH: (Month) (Day) (Year): Feb 20th 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 12/13/1884
9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR: Months 2, Days 7; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10b. KIND OF BUSINESS OR INDUSTRY: Eagle Dress Co
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wilhelm Hormann
14. MOTHER'S MAIDEN NAME: Charlotte Piepbenbrient

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: 215-07-4024
17. INFORMANT & ADDRESS: Wm P. Harvey 5411 Wasena Ave

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

443X

Immediate cause (a) Cerebral Vascular Accident — Rite
DUE TO

Antecedent cause(s) (b) Generalized A.S.V.H.D.
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO
(c) —

INTERVAL BETWEEN ONSET AND DEATH: X

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 2-9, 1954, to 2-20, 1954, that I last saw the deceased alive on 2-19, 1954, and that death occurred at 3 a.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
A Plosnowski MD 4016 Ritchie Hwy 2-22-54

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 2/23/54
NAME OF CEMETERY OR CREMATORY: London Park
LOCATION (City, town, or county) (State): Balto. Md.

DATE REC'D BY LOCAL REG.: 2-23-54
REGISTRAR'S SIGNATURE: A. W. Hedrick
24. FUNERAL DIRECTOR: Wm Cook Inc. 1217 St. Paul St.
ADDRESS:

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01199 21

1. PLACE OF DEATH:
COUNTY ANNE ARUNDEL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 18½ MARKET SPACE

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY A.A.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS
STREET ADDRESS (If rural give location) 18½ MARKET SPACE ANNAPOLIS

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) M. FISHER (Last) HAUSNER

4. DATE OF DEATH: (Month) FEBRUARY (Day) 15 (Year) 1954

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH: JULY 8, 1877
9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): ANNAPOLIS, MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John WINTERLE
14. MOTHER'S MAIDEN NAME: Mary NICHOLS

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) *** (If Yes, give war or dates of service) ******
16. SOCIAL SECURITY No.: ******
17. INFORMANT & ADDRESS: MRS RUTH LOMBOY DAUGHTER SAME AS # 2

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0
Immediate cause (a) Arterio Sclerotic Heart Disease
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Generalized Arterio Sclerosis
DUE TO
(c)

Interval Between Onset And Death: Several years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1953 to Feb 15, 1954, that I last saw the deceased alive on Feb 15, 1954, and that death occurred at 8 A.M., from the causes and on the date stated above.

SIGNATURE George C. Basil (Degree or title) M. D. ADDRESS Annapolis Md DATE SIGNED 2-16-54

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
DATE THEREOF 2-17-54
NAME OF CEMETERY OR CREMATORY ST MARY'S CEMETERY
LOCATION (City, town, or county) (State) ANNAPOLIS, MARYLAND
DATE REC'D BY LOCAL REGISTRAR Feb 16, 1954
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR BEN L. HOPPING AND SON ADDRESS ANNAPOLIS, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Heights
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 301 Jerome Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Heights
STREET ADDRESS (If rural, give location) 301 Jerome Ave.

3. NAME OF DECEASED (Type or Print) (First) SOPHIA (Middle) (Last) HOMENS
4. DATE OF DEATH (Month) Feb. (Day) 7 (Year) 1954

5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed
8. DATE OF BIRTH June 6, 1873
9. AGE last birthday 80 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joseph Aulbach
14. MOTHER'S MAIDEN NAME Marie Kramer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. no
17. INFORMANT AND ADDRESS Mr. William A. Homens - 301 Jerome Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
331X Immediate cause	(a) Cerebral Hemorrhage	1/6/54
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio-Sclerosis & Hypertension	7/24/32
	(c) Cerebral Hemorrhage	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/24, 1932, to 2/7, 1954, that I last saw the deceased alive on 2/6/, 1954, and that death occurred at 3:45 P m., from the causes and on the date stated above.

SIGNATURE Eliot W. Johnson MD (Degree or title) ADDRESS 3432 Frederick Ave Balt Md 24 Md DATE SIGNED 2/8/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 2/11/54
NAME OF CEMETERY OR CREMATORY New Cathedral Cem.
LOCATION (City, town, or county) (State) Balto., Md.

DATE REC'D BY LOCAL REG. 2-8-54
REGISTRAR'S SIGNATURE A W Hedrick
24. FUNERAL DIRECTOR Wm. J. Pickner & Sons ADDRESS Balto. 17, Md.

1187

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 01

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md.
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY A. A.
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) Chester Ave

3. NAME OF DECEASED: (Type or Print) (First) Louis (Middle) S (Last) Hudson.

4. DATE OF DEATH (Month) 2 (Day) 16 (Year) 1954

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: Sept 27-1878
9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Salesman Pet
10b. KIND OF BUSINESS OR INDUSTRY: Hardware
11. BIRTHPLACE (State or foreign country): Stony Brook N.Y.
12. CITIZEN OF WHAT COUNTRY? N.S.A.

13. FATHER'S NAME: Albert N. Hudson
14. MOTHER'S MAIDEN NAME: Adell Smith.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) no
16. SOCIAL SECURITY No.: 111-12-1400
17. INFORMANT & ADDRESS: Albert W. Hudson Stony Brook N.Y.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Gunshot - Wound - Skull. DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: Sudden

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boat
21c. (City or town) Annapolis (County) A.A. Co (State) MD
21d. TIME OF INJURY (Month) 2 (Day) 16 (Year) 54 (Hour) P M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☑
21f. HOW DID INJURY OCCUR? Suicide

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☑, Homicide ☐, Undetermined cause ☐.

SIGNATURE E. Lim Lacat M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 2/16/54

23. ~~BURIAL, CREMATION,~~ REMOVAL (Specify): DATE THEREOF 2-17-54
NAME OF CEMETERY OR CREMATORY
LOCATION (City, town, or county) Port Jefferson L.I. (State) N.Y.

DATE REC'D BY LOCAL REG. Feb. 17, 1954
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Layke Sons ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

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12-5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. (1) ... 01202

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ferndale Glen Burnie P.O.
LENGTH OF STAY (in this place): 3 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 214 Williams Road

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE: Maryland
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ferndale Glen Burnie P.O.
STREET ADDRESS (If rural give location): 214 Williams Road

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) Louis (Last) January

4. DATE OF DEATH: (Month) 2 (Day) 9 (Year) 1954

5. SEX: Mal

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 1/20/91

9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Electrician (retired)

10b. KIND OF BUSINESS OR INDUSTRY: Panama Canal Zone

11. BIRTHPLACE (State or foreign country): Church Creek, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph January

14. MOTHER'S MAIDEN NAME: Lurene Degaff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: unknown

17. INFORMANT & ADDRESS: Mrs. Anna L. January - Ferndale, Glen Burnie P.O.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260 X
Immediate cause (a) Coronary Thrombosis — Interval Between Onset And Death: 1 Mo

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) arteriosclerosis
DUE TO (c) Diabetes Mellitus

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to Feb, 1954, that I last saw the deceased alive on 2-2, 1954, and that death occurred at 8.15 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title): Charles R. MacDonald M.D. — ADDRESS: Glen Burnie, Md. — DATE SIGNED: 2-9-54

23. BURIAL, CREMATION, REMOVAL (Specify): Cremation — DATE THEREOF: 2/12/54 — NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery — LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR: February 12, 1954 — REGISTRAR'S SIGNATURE: L. H. Allen

24. FUNERAL DIRECTOR: Richard V. Singleton — ADDRESS: Glen Burnie, Md.

VS. A15

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3

Anne Arundel

1. PLACE OF DEATH: COUNTY 234 - 2nd ave Patapsco Pk MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
LENGTH OF STAY (in this place) 10 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE 234 2nd ave Patapsco Pk COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore Md
STREET ADDRESS (If rural, give location) 234 2nd ave Patapsco Park

3. NAME OF DECEASED (Type or Print) (First) DORA (Middle) (Last) JOHNSON
4. DATE OF DEATH (Month) 2 (Day) 2 (Year) 54

5. SEX female
6. COLOR OR RACE Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH unk. 1887
9. AGE last birthday 66 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY House Work
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME unknown
14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No. —
17. INFORMANT AND ADDRESS Thomas J. Smith 724 Bradley St

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Haemorrhage — 3 weeks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio-Sclerosis — 5 yrs

(c) Hypertension — 5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/22/54, 19....., to 2/2/54, 19....., that I last saw the deceased alive on 2/2/54, 19....., and that death occurred at 8 P. m., from the causes and on the date stated above.

SIGNATURE Chas. L. Ball Jr. (Degree or title) ADDRESS Linthicum DATE SIGNED 2/4/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 2-6-54
NAME OF CEMETERY OR CREMATORY Mt Auburn Cem
LOCATION (City, town, or county) Baltimore (State) Md

DATE REC'D BY LOCAL REG. 2/5/54
REGISTRAR'S SIGNATURE S.W. Hedrick
24. FUNERAL DIRECTOR William A. Jackson 916 Penna ave ADDRESS

Dwse

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 0 204

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater
LENGTH OF STAY (in this place) 13 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY A. A. Co.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo, Md.
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Margaret (Middle) MARY (Last) Jones

4. DATE OF DEATH: (Month) Feb. (Day) 27 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify):

8. DATE OF BIRTH: 1894

9. AGE last birthday: 60 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): IRELAND

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: JAME O'BRIEN

14. MOTHER'S MAIDEN NAME: MARY MULLANE

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Mrs. Nicholas Lucker Mayo, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cerebral hemorrhage — Interval Between Onset And Death: 1 hour

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerosis — 10 years

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 27, 1954, to Feb. 27, 1954, that I last saw the deceased alive on ——, 19—, and that death occurred at 4 a.m., from the causes and on the date stated above.

SIGNATURE Vincent Gould (Degree or title) M.D. ADDRESS Mayo, Md. DATE SIGNED

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify) DATE THEREOF 3/2/54 NAME OF CEMETERY OR CREMATORY Mt. St. Marys Cemetery LOCATION (City, town, or county) JAMAICA L.I. (State) N. York

DATE REC'D BY LOCAL REGISTRAR March 1, 1954 REGISTRAR'S SIGNATURE Edward Collinson

24. FUNERAL DIRECTOR John M. Taylor & Sons ADDRESS Annapolis, Md

Dead on arrival. No physician attending. Signing of death certificate authorized by Elmer C. Linhardt, M.D.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]205

CERTIFICATE OF DEATH

Reg. Dist. No. ....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Harmans — LENGTH OF STAY (in this place): Life

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Old Coaling Road

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Same — COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Same

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last): Laura Virginia Journey

4. DATE OF DEATH: (Month) (Day) (Year): February 23 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Widow	9/24/72	81 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Harmans, Maryland.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Samuel Durner	Mary Ann Watts

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
No	None	Calvin Durner, Harmans, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause (a)	General Arteriosclerosis	3 y.
DUE TO		
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)	Hypertension	3 y.
DUE TO		
(c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan. ....., 19 51, to Feb. 23 ....., 1954, that I last saw the deceased alive on 2/20/54 19....., and that death occurred at 4.50 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Gustav K. Pankenbrock	Glen Burnie, Md.	2/23/54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	February 26, 1954	Friendship	Old Camp Meade Road, Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
February 26, 1954	L. J. D'Alba	R. K. Singleton	Glen Burnie, Md.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

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Reg. Dist. No. 2 c

MARGIN RESERVED FOR BINDING

PLAINLY WITH UNFADING INK. Supply every item of information carefully. The coroner especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Anne Arundel; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: P.O.Arnold
LENGTH OF STAY (in this place): 3 Y.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Belvedere Beach

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Same; COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Same
STREET ADDRESS (If rural, give location): Same

3. NAME OF DECEASED (Type or Print): (First) Charles Calvert (Middle) Keyes (Last)

4. DATE OF DEATH: (Month) Feb (Day) 22 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 4/10/85

9. AGE last birthday: 68 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Owner and keeper.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Calvert County

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Keyes

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Mary Keyes (wife.)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

974.X

Immediate cause (a) Strangulation with a rope tied around — Interval Between Onset and Death: Sudden

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) his neck.(Suicide)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home (CITY OR TOWN): Beverdale Beach (COUNTY): A.A. (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): 2/22/54 8.30 P.M. INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? By placing a rope around his neck.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐.*

SIGNATURE: Gustave A Faulenbach (Degree or title): Deputy medical examiner ADDRESS: Glen Burnie Md. DATE SIGNED: 2/23/54

FINAL DISPOSITION (Burial, Cremation, Removal, (Specify)): Burial

DATE THEREOF: Feb 25 1954

NAME OF CEMETERY OR CREMATORY: Holy Cross Brookland

LOCATION (City, town, or county) (State): Baltimore Highway G.B. Co

DATE REC'D BY LOCAL REG.: Feb 23, 1954

REGISTRAR'S SIGNATURE: L Davis

24. FUNERAL DIRECTOR: Ernest Litsinger ADDRESS: Glen Burnie Md.

VS A15A

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (1507

CERTIFICATE OF DEATH

Reg. Dist. No. 23

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
LENGTH OF STAY (in this place) 4 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1500 Ingalls Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A.A.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie (Harundale)
STREET ADDRESS (If rural give location) 1500 Ingalls Road

3. NAME OF DECEASED: (Type or Print) (First) ALICE (Middle) MAUDE (Last) LEWIS
4. DATE OF DEATH: (Month) February (Day) 2 (Year) 1954

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: May 8, 1872
9. AGE last birthday: 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Ret. Saleslady
10b. KIND OF BUSINESS OR INDUSTRY: Department Store
11. BIRTHPLACE (State or foreign country): Baltimore City, Md.
12. CITIZEN OF WHAT COUNTRY? Yes - USA

13. FATHER'S NAME: J. Frederick Lewis (deceased)
14. MOTHER'S MAIDEN NAME: ~~Mrs Ida Baugher~~ Mary Ann Mae Fadden (dec)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: 220-07-7269
17. INFORMANT & ADDRESS: Mrs Ida Baugher (sister)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
422.2 Immediate cause	(a) chronic myocarditis	3 weeks
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) chronic cirrhosis of liver	2 yrs
	DUE TO (c) General senility	10 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) None
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 12 Jan, 1954, to 2 Feb, 1954, that I last saw the deceased alive on 1 Feb, 1954, and that death occurred at 4:30 PM, from the causes and on the date stated above.

SIGNATURE H.F. Manuzak (Degree or title) M.D. ADDRESS 901 Edgerly Rd, Glen Burnie, Md. DATE SIGNED 2 Feb 1954

23. BURIAL, CREMATION, REMOVAL. (Specify) Burial
DATE THEREOF 2/5/54
NAME OF CEMETERY OR CREMATORY Loudon Park
LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR 2/3/54
REGISTRAR'S SIGNATURE W. Hedrick
24. FUNERAL DIRECTOR Wm. Cook, Inc. ADDRESS 1217 St. Paul Street

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VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 C1208

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS HOMEWOOD CONVALESCENT HOME

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 125 E. Churchill St.

3. NAME OF DECEASED: (Type or Print) (First) Lillie (Middle) (Last) McKNIGHT
4. DATE OF DEATH: (Month) (Day) (Year) 2/15/54 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F	W	Widowed	6/20/1881	72 yrs.		

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Baltimore, Md.	

13. FATHER'S NAME: Louis Sline
14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	-	-	Miss Doris McKnight 125 E. Churchill

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) DUE TO: Cerebral Vascular Accident — Interval Between Onset And Death: 4 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO: Arteriosclerosis — unknown

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-12-1954, to 2-15-1954, that I last saw the deceased alive on 2-15, 1954, and that death occurred at 9 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Edward S. Beck MD 41 Southgate Ave. Annapolis 2-17-54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/18/54	Cedar Hill	Ritchie Hgwy

DATE REC'D BY LOCAL REGISTRAR: 2/19/54 — REGISTRAR'S SIGNATURE: C. W. Hedrick

24. FUNERAL DIRECTOR — ADDRESS: JOHN F. DENNY, INC. 715 Light St.

DC L

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1221

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01209

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY ANNE ARUNDEL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLERSVILLE (RURAL) MD
LENGTH OF STAY (in this place) 32 YEARS
HOSPITAL OR INSTITUTION OR STREET ADDRESS WHITNEYS LANDING ROAD ELYATON.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY A. A.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLERSVILLE (RURAL) MD.
STREET ADDRESS (If rural give location) WHITNEYS LANDING ROAD, ELYATON, MD

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
FREDERICK	AUGUST	MIELKE	FEB.	18	1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	MARRIED	MAY 3, 1887	66 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
CARPENTER (RET'D)	GENERAL	GERMANY	unknown

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
WILHELM MIELKE	MATILDA DAMMER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	223-05-2095	MRS. AMELIA MIELKE, ELYATON MILLERVILLE, MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) Carcinoma of Prostate gland — Interval Between Onset And Death: 4 years

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) .... DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec. 19, 1950, to Feb. 18, 1954, that I last saw the deceased alive on Feb. 17, 1954, and that death occurred at 1:30 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Randall M. McLaughlin	M.D.	Pasadena, Md.	Feb. 18, 1954

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	2-20-54	Cedar Hill	BROOKLYN MD (RURAL)

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 20, 1954	L J D'Alba	W Singleton	Glen Burnie, Md

VS. A15

FEB
BUREAU V. S.

1189

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 49 N. Washington

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A.A.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
STREET ADDRESS (If rural give location) 49 N. Washington St.

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) (Last) Miller

4. DATE OF DEATH: (Month) 2 (Day) 19 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M
8. DATE OF BIRTH: 3-14-1882
9. AGE last birthday: 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Hotel
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Annapolis Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Miller
14. MOTHER'S MAIDEN NAME: Catherine Ross

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No: 218-14-2253
17. INFORMANT & ADDRESS: Mrs. Sarah Miller - 49 N. Washington St.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

Immediate cause (a) Cardiac Failure — Interval Between Onset And Death: 2 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Hypertensive Cardio-Vascular Disease — 2 yrs

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify, that I attended the deceased from 2/18, 1954, to 2/19, 1954, that I last saw the deceased alive on 2/19, 1954, and that death occurred at 11:10 P.M.; from the causes and on the date stated above.

SIGNATURE Theodore H. Johnson (Degree or title) M.D. ADDRESS 40 Northwood Street Annapolis, Md. DATE SIGNED 2/20/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 2-22-54
NAME OF CEMETERY OR CREMATORY St. Anne
LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 22, 1954
REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR William Rees II - 108 N. Washington St. Annapolis, Md.
ADDRESS

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BUREAU V. S.

Item 22 Film G 161 3/3/54

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fort George G. Meade
LENGTH OF STAY (in this place): 10 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U. S. ARMY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Pennsylvania — COUNTY: Schuylkill
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Tamaqua
STREET ADDRESS (If rural give location): 437 Pine St.

3. NAME OF DECEASED: (Type or Print) (First) Edward (Middle) Michael (Last) Moran Jr.

4. DATE OF DEATH: (Month) February (Day) 17 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 18 April 1932

9. AGE last birthday: 21 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Army

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward M. Moran, Sr.

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes — (If Yes, give war or dates of service): Nov 49-Nov 52 Mar 53-Feb 54

16. SOCIAL SECURITY No.: Unknown

17. INFORMANT & ADDRESS: Military Personnel, Fort George G. Meade, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause: (a) Pulmonary and brain hemorrhage

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) with fractured skull and fractured left femur — 2 hrs.
DUE TO (c) due to trauma.

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Suicide
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Office building — (CITY OR TOWN): Fort George G. Meade — (COUNTY): Anne Arundel — (STATE): Maryland
TIME OF INJURY (Month) (Day) (Year) (Hour): Feb 17 1954 0715
INJURY OCCURED While at Work ☐ Not While At Work ☒
HOW DID INJURY OCCUR? Jumped from building.

22. I hereby certify that I attended the deceased from 17 Feb, 19 54, to 17 Feb, 19 54, that I last saw the deceased alive on 17 Feb 1954, and that death occurred at 9:30 AM, from the causes and on the date stated above.

SIGNATURE: Donald R. Watkins — (Degree or title): Capt., MC — ADDRESS: U. S. ARMY HOSPITAL, Fort Geo G. Meade, Md. — DATE SIGNED: 17 Feb 54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 20 Feb 54
NAME OF CEMETERY OR CREMATORY: Protestant Cemetery
LOCATION (City, town, or county) (State): Tamaqua, Pennsylvania

DATE REC'D BY LOCAL REGISTRAR: 23 Feb 54
REGISTRAR'S SIGNATURE: T.A.GORDON, CWO, USA

24. FUNERAL DIRECTOR ADDRESS: WM. COOK, INC. Baltimore, Maryland

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1223

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 61212

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
LENGTH OF STAY (in this place) 17 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 113 - Third Ave. S.E.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
STREET ADDRESS (If rural give location) 113 - Third Ave. S.E.

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) (Last) Neserke

4. DATE OF DEATH: (Month) 2 (Day) 1 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept. 16, 1884

9. AGE last birthday: 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) Insurance Agent (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: L. A. Benson Co.

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Charles C. Neserke

14. MOTHER'S MAIDEN NAME: Dora Pistone

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO: 216-05-9689

17. INFORMANT & ADDRESS: Mrs Raymond L. Atwell - Glen Burnie Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 151X DUE TO Carcinoma Stomach

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) ..... DUE TO

(c)

Interval Between Onset And Death: 6 mos.

II OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 12-30-53

19b. MAJOR FINDINGS OF OPERATION Carcinoma stomach & metastasis

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 53, to Feb. 54, that I last saw the deceased alive on 2-1-54, and that death occurred at 9 45 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) C. R. MacDonald MD — ADDRESS 204 Crain Hwy, Glen Burnie, Md. — DATE SIGNED 2-1-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 2/3/54 — NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery — LOCATION (City, town, or county) Glen Burnie — (State) Md. — ADDRESS

DATE REC'D BY LOCAL REGISTRAR 2/4/54 — REGISTRAR'S SIGNATURE L. J. DeLeon

24. FUNERAL DIRECTOR P. V. Singleton — Glen Burnie, Md.

BUREAU V. S.

1224

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8

1. PLACE OF DEATH:

COUNTY A. A. MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS 302 Riverview Rd

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY A. A.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn

STREET ADDRESS (If rural, give location) 302 Riverview Rd.

3. NAME OF DECEASED: (Type or Print) (First) Alfred (Middle) K. (Last) Newton

4. DATE OF DEATH: (Month) Feb. (Day) 13th (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced	6/8/1705	48 yrs.	8	5		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Shipfitter	Beth. Ship Yards	Pa.	

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	219-10-8336	Jacob H. Smith Jr. 302 Riverview Rd Brooklyn

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

163.7

Immediate cause (a) Carcinoma of Pleura — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 1/28, 1954 to 2/13, 1954, that I last saw the deceased alive on 2/13, 1954 and that death occurred at 1:30 P.M., from the causes and on the date stated above.

SIGNATURE Samuel Ryba (DEGREE OR TITLE) M.D. ADDRESS 203 Baltimore Ave DATE SIGNED

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR ~~CREMATORY~~	LOCATION (City, town, or county) (State)
Burial	2/16/54	Glen Haven	A. A. Co. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-17-54	LL	Wm. Cook Inc.	1217 N. Eutaw St.

1190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 24 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 39 Northwest Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 39 Northwest Street

3. NAME OF DECEASED (Type or Print) (First) Hoarce (Middle) Carroll (Last) Pack
4. DATE OF DEATH (Month) (Day) (Year) 19 2/24/1954
5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 6/14/1894
9. AGE last birthday 59 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Arnold, A.A. Co. Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William Pack
14. MOTHER'S MAIDEN NAME Lola Fleetwood
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS Carrie Pack-39 Northwest St. Annapolis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

Immediate cause (a) Uremia Coma — INTERVAL BETWEEN ONSET AND DEATH 12 hrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension Cardio — Vascular disease — 7 [illegible]

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1953, to Feb 24, 1954, that I last saw the deceased alive on Feb 24, 1954, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE [illegible] (Degree or title) M.D. ADDRESS 110 — Clay St Anne Polis, Md. DATE SIGNED 2/24/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 2/27/1954
NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery
LOCATION (City, town, or county) West St. Annapolis, Md. (State)

DATE REC'D BY LOCAL REG. Feb. 26, 1954
REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR Ethel L. Hicks-45 Northwest St. Annapolis Md. ADDRESS

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MAR 1 1954
BUREAU V. S.

1225

MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

0215

Reg. Dist. No. 2-8

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville State Hospital
LENGTH OF STAY (in this place): 37 yrs. 3 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Unknown
STREET ADDRESS (If rural, give location): Unknown ✓

3. NAME OF DECEASED (Type or Print): (First) Ella (Middle) (Last) Pryor

4. DATE OF DEATH: (Month) 2 (Day) 23 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 1876?

9. AGE last birthday: 77? yrs. If under 1 year: Months — Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk. (If year, give war or dates of service): Unk.

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Senile Marasmus, myocardial degeneration — 2 years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)..... (c)....

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Schizophrenia, Paranoid Type. — 37¼ years 10 days
Wounds from burns

19a. DATE OF OPERATION: - - - - -

19b. MAJOR FINDINGS OF OPERATION: - - - - -

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): - - - - -

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: - - - - -

(CITY OR TOWN) (COUNTY) (STATE): - - - - -

TIME OF INJURY (Month) (Day) (Year) (Hour): - - - - - m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? - - - - -

22. I hereby certify that I attended the deceased from 6/20, 19 48, to 2/23, 19 54, that I last saw the deceased alive on 2/23, 19 54, and that death occurred at 12:50 a.m., from the causes and on the date stated above.

SIGNATURE: A. Bunchel M.D. (Degree or title) ADDRESS: Crownsville, Md. DATE SIGNED: 2/23/54

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) DATE: 2/26/54 NAME OF CEMETERY OR CREMATORY: Crownsville St. Hospital LOCATION (City, town, or county): Crownsville (State): Md

DATE REC'D BY LOCAL REG.: 2-24-54 REGISTRAR'S SIGNATURE: [illegible]

24. FUNERAL DIRECTOR: Arnold H. Eichelberger M.D. ADDRESS: Crownsville Md

MARGIN RESERVED FOR BINDING

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Lived Few Hours

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF ~~STILLBIRTH~~ Death

Reg. Dist. No. 21

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF STILLBIRTH
County: A. A. Co Md — MARYLAND
City or Town (If outside city or town limits write "RURAL" and nearest town): Annapolis Md
Street address, hospital or institution: Franklin St - Annapolis, Md
Length of mother's stay in this County (Give years, or months or days): 14 yrs - 27 days

2. USUAL RESIDENCE OF MOTHER
State: 51 Shaw St - Annapolis, Md
County: A. A. Co
City or Town (If outside city or town limits write "RURAL" and nearest town): Annapolis, Md
Street Address: 51 Shaw St

(First) (Middle) (Last)

3. CHILD'S NAME Baby Girl

4. Sex: F
5. Twin or other: NO — If so, born 1st, 2nd, 3rd
6. DATE OF BIRTH (Month WRITE OUT) (Day) (Year): Feb. 9, 1954 — 19

FATHER OF CHILD
7. Full name: George Purdy
8. Color or race: Col.
9. Age (at time of this birth): 20 yrs.
10. Birthplace (State or foreign country): Virginia - U.S.A.
11. Usual occupation: Soldier - U.S. Army
Kind of business or industry: U.S. Army

MOTHER OF CHILD
12. Full maiden name: Sylvia Ann Brown
13. Color or race
14. Age (at time of this birth): 14 yrs.
15. Birthplace (State or foreign country): Annapolis Md
16. Number of OTHER children born to mother (Do NOT include this child): Now living | Born alive but now dead | Born dead | Total Children (Not including this child) — (None)
17. Length of pregnancy: 20 weeks — Weight of child at birth: 2 lbs. 4 oz.

18. CAUSE OF STILLBIRTH State only morbid conditions causing fetal death (do NOT use such terms as Stillbirth, Prematurity, Asphyxia, etc.)
(a) Fetal causes: Unknown (776X)
(b) Maternal causes: Unknown

19. State any complications of pregnancy and labor: None
20. State all operations for delivery: (None)

~~Burial~~, Cremation, ~~Removal~~, (Specify) — Date: Feb. 17, 1954
Cemetery or Crematory: ANNE ARUNDEL GENERAL HOSPITAL
Location: ANNAPOLIS, MARYLAND
~~Funeral Director~~: Sherrill S. Adams
SHERRILL S. ADAMS
ADMINISTRATOR

21. I hereby certify that this child was born dead on the date stated above at 3:13 ~~2 mt~~ pm.
Signature: Albert Anderson
Physician ☑ Midwife ☐ Other ☐
Address: Annapolis, Md — Date signed: 2/9/54

Date rec'd by local Reg.: Feb. 17, 1954 — Registrar's signature: [illegible] — If NOT attended by physician

"The above certificate has been examined by me."
Health Officer, per

V.S. A10

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:
COUNTY A.A. County MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN West River
LENGTH OF STAY (In this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY A.A.
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN West River
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Alverta (Middle) (Last) Ross

4. DATE OF DEATH (Month) 2 (Day) 26 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 30 1886
9. AGE last birthday: 57/57 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Tracy Landing Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel Gross
14. MOTHER'S MAIDEN NAME: Martha Gross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT & ADDRESS: Alfred Ross, West River, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: INTERVAL BETWEEN ONSET AND DEATH

.331X

Immediate cause (a) Cerebral Hemorrhage.
DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.,
21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☑
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: Elmer Raeth M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED

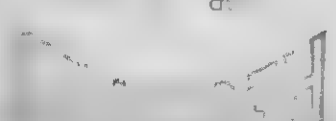
23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 2/28/54
NAME OF CEMETERY OR CREMATORY Union Chapel
LOCATION (City, town, or county) McKendree Md (State)

DATE REC'D BY LOCAL REG. 2/28/54
REGISTRAR'S SIGNATURE Ek. West William
24. FUNERAL DIRECTOR Hardesty Funeral Home, Galesville Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

61218

CERTIFICATE OF DEATH

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dorsey; LENGTH OF STAY (in this place) 7 months; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dorsey Md; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) E. (Last) SEWELL

4. DATE OF DEATH: (Month) Feb (Day) 18 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Baby

8. DATE OF BIRTH: July 17 1953

9. AGE last birthday: If under 1 year: Months; Days; If under 24 hrs.: Hours; Min. 7 months

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Dorsey Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Sewell

14. MOTHER'S MAIDEN NAME: Hazel Long

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Hazel Sewell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

780.2

Immediate cause (a) Convulsions, Infantile —

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cause undetermined

(c)

INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 18th 1954, to Feb. 18th, 1954; that I last saw the deceased alive on Feb 18, 1954, and that death occurred at 11 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Mankin Ridgley, M.D. ADDRESS Savage Md DATE SIGNED 2/19/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Feb 20 1954

NAME OF CEMETERY OR CREMATORY: St. Martin

LOCATION (City, town, or county): Anne Arundel (State): Md

DATE REC'D BY LOCAL REG.: Feb 19 54

REGISTRAR'S SIGNATURE: Elaine Haskett

24. FUNERAL DIRECTOR: Ridgley Selby ADDRESS 401 Washington Laurel Md

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G. Meade | LENGTH OF STAY (in this place) Unknown
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. ARMY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Georgia — COUNTY De Kalb
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Decatur
STREET ADDRESS (If rural, give location) 784 E. College Ave.

3. NAME OF DECEASED (Type or Print): (First) Marshall (Middle) Dow (Last) Shelnutt
4. DATE OF DEATH: (Month) February (Day) 11 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 8 Sep 1953
9. AGE last birthday: yrs. If under 1 year: Months 5, Days 2. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Texas
12. CITIZEN OF WHAT COUNTRY: United States

13. FATHER'S NAME: Hubert Lamar Shelnutt
14. MOTHER'S MAIDEN NAME: Lillian Pattillo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT AND ADDRESS: Marshall D. Shelnutt Qrs 2322A, Ft. Meade, Md. (Father)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Tracheo bronchitis	2 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Bronchopneumonia	2 days
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11 Feb, 1954, to 11 Feb, 1954, that I last saw the deceased alive on 11 Feb, 1954, and that death occurred at 10:20 P m., from the causes and on the date stated above.

SIGNATURE: Floyd A Svec
(Degree or title): Capt - MC
ADDRESS: USAN. Ft Geo. Meade. Md.
DATE SIGNED:

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 13 Feb 54
NAME OF CEMETERY OR CREMATORY: Ft. Geo. G. Meade Cemetery
LOCATION (City, town, or county) (State): Ft. Geo. G. Meade, Md.

DATE REC'D BY LOCAL REG.: 11 Feb 54
REGISTRAR'S SIGNATURE: T. A. GORDON CWO USA
21. FUNERAL DIRECTOR: Lt. Col. Marsh
ADDRESS: Ft. Meade, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fort George G. Meade
LENGTH OF STAY (in this place): Unknown
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U. S. ARMY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Massachusetts — COUNTY: Suffolk
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Needham
STREET ADDRESS (If rural, give location): 187 South St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Roger	Wight	Sherman Jr.	February	12	1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Single	31 March 1930	23 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Soldier	U. S. Army	Massachusetts	United States

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Roger Wight Sherman Sr.	Augusta unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
Yes	8/11/53 to 2/12/54	Unknown	Military Personnel Fort George G. Meade, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) 040.0 Poliomyelitis - Acute, Anterior bulbar. — 2 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10 Feb, 1954, to 12 Feb, 1954, that I last saw the deceased alive on 12 Feb, 1954, and that death occurred at 340 A m., from the causes and on the date stated above.

SIGNATURE: Floyd A Svec — (Degree or title): Capt mc. — ADDRESS: USAN. Ft. G.G. Meade. Md. — DATE SIGNED: 12 Feb 54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb 16, 1954	Needham Cemetery	Needham, Massachusetts

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
12 Feb 54	T. A. GORDON CWO USA	William Cook Inc.	Baltimore, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU V. S.

1192

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Creek

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md
STREET ADDRESS (If rural give location) Weems Creek

3. NAME OF DECEASED: (Type or Print) (First) SAMUEL (Middle) ROGER (Last) SMITH

4. DATE OF DEATH: (Month) 2 (Day) 21 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Write) Married

8. DATE OF BIRTH: Aug-29-1896

9. AGE last birthday: 57 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Trucking Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Trucking

11. BIRTHPLACE (State or foreign country): London Co Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Smith

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Cecelia E. Smith Weems Creek Annapolis Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 8 hrs

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Arterial Hypertension — Several years

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 20 ,1954, to Feb 21 ,1954, that I last saw the deceased alive on Feb 21, 1954, and that death occurred at 12.10 PM., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. Oliver Purvis M.D. — ADDRESS 40 Franklin St. Annapolis Md — DATE SIGNED 2/23/54

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF 2-24-54 — NAME OF CEMETERY OR CREMATORY Hill Crest — LOCATION (City, town, or county) (State) Annapolis Md

DATE REC'D BY LOCAL REGISTRAR Feb. 24, 1954 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR John M. Taylor Sons — ADDRESS Annapolis Md

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 1222

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jones Station
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Severna Park, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jones Station
STREET ADDRESS (If rural give location) Severna Park

3. NAME OF DECEASED: (Type or Print) (First) PETER (Middle) (Last) SNELLINGS

4. DATE OF DEATH: (Month) February (Day) 11 (Year) 19 54

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: March 18 1869
9. AGE last birthday: 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Ret. Merchant
10b. KIND OF BUSINESS OR INDUSTRY: General Store
11. BIRTHPLACE (State or foreign country): Stafford, Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) --- (If Yes, give war or dates of service) ---
16. SOCIAL SECURITY No.: -----
17. INFORMANT & ADDRESS: Mr. Appie Snellings, son same as # 2

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

422.1
Immediate cause (a) Degenerative cardio-vascular disease — 5 yrs.
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Generalized arteriosclerosis — 10 yrs.
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1952, to Feb 11, 1954, that I last saw the deceased alive on Feb 11, 1954, and that death occurred at 7.50 PM, from the causes and on the date stated above.

SIGNATURE General Treeton (Degree or title) M.D. ADDRESS Severna Park, Md DATE SIGNED Feb 12, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 2/14/54
NAME OF CEMETERY OR CREMATORY Halls Memorial Cemetery
LOCATION (City, town, or county) (State) Stafford, Va.
DATE REC'D BY LOCAL REGISTRAR Feb 13, 1954
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Ben L. Hopping and Son ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 18 ..-
BUREAU V. S.

1231

M

MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 23) 5

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville ✓ LENGTH OF STAY (in this place) 8 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital	STREET ADDRESS (If rural, give location) 912 Washington Street ✓

3. NAME OF DECEASED (Type or Print) (First) Garfield (Middle) (Last) Stokes			4. DATE OF DEATH (Month) 2 (Day) 3 (Year) 1954	
5. SEX Male	6. COLOR OR RACE Negroid	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1/1/19	9. AGE last birthday 35 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Va.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS Hospital Records	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

300.2

Immediate cause (a) Acute cardiac failure

Antecedent cause(s) (b) Dehydration and exhaustion — 2 days

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Schizophrenia, Catatonic Type — Known to us since 1/26/54

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/26, 1954, to 2/3, 1954, that I last saw the deceased alive on 2/3, 1954, and that death occurred at 9:00 a. m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) ADDRESS Crownsville, Md. DATE SIGNED 2/3/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Feb. 6/54	NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem	LOCATION (City, town, or county) A.A. County (State) Md
DATE REC'D BY LOCAL REG. 2/5/54	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR Mrs. Robt. G. Elliott & Daughter	ADDRESS 1129 N. Carolina St

MARGIN RESERVED FOR BINDING

1

L. Bennett

1232

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18[illegible]24

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town): Severna Park; LENGTH OF STAY (in this place): 9 mo.; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Severna Park Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Severna Park; STREET ADDRESS (If rural give location): Severna Park Md

3. NAME OF DECEASED (Type or Print): (First) Herbert (Middle) Raymond (Last) Sulzer

4. DATE OF DEATH: (Month) 2 (Day) 22 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: 12-17-82

9. AGE last birthday: 71 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Self employed - Brass Foundry

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Phila. Pa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gustav W. F. Sulzer

14. MOTHER'S MAIDEN NAME: Christiana L. Lutz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 194-12-2756

17. INFORMANT & ADDRESS: Mr W. Kansle Severna Park Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 162.X Broncho pneumonia — Interval Between Onset And Death: 2 weeks

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Broncho genic carcinoma — —

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1954, to Feb. 22, 1954, that I last saw the deceased alive on Feb. 22, 1954, and that death occurred at 4:30 PM, from the causes and on the date stated above.

SIGNATURE Francis D. Codd (Degree or title) M.D 2-22-54 ADDRESS Severna Park Md DATE SIGNED 2-22-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 2-25-54 — NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery — LOCATION (City, town, or county) Philadelphia (State) Pa

FILED BY LOCAL REGISTRAR 2-23-54 — REGISTRAR'S SIGNATURE W W Hegner — 24. FUNERAL DIRECTOR John A. Moran per HB Lewis — ADDRESS 3000 E. Baltimore

VS. A15

1233 Film#G161 Item# 9 2/3/54 emf

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01226

CERTIFICATE OF DEATH

Reg. Dist. No. 73

1. PLACE OF DEATH: Anne Arundel
COUNTY Anaranda MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Burnie
LENGTH OF STAY (in this place) 4 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 205 3rd Ave S.W.

2. USUAL RESIDENCE (HOME) OF DECEASED: Anne Arundel
STATE Md. COUNTY Anaranda
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Burnie
STREET ADDRESS (If rural give location) 205 3rd Ave S.W.

3. NAME OF DECEASED: (Type or Print) (First) Ida (Middle) Frances (Last) Thompson

4. DATE OF DEATH: (Month) Feb. (Day) 4 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: Nov. 19, 1876

9. AGE last birthday: 77 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Kline

14. MOTHER'S MAIDEN NAME: Gemima Winaro Lynch

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO.: no

17. INFORMANT & ADDRESS: Mrs. Samuel Crawford 205 3rd Ave. S.W. Glenn Burnie, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 421.4 (a) Mitral Insufficiency — Interval Between Onset And Death: 3 years

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Hypertension — 3. y.

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January 1951, to Feb. 4, 1954, that I last saw the deceased alive on Feb. 2, 1954, and that death occurred at 2.15 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Gustave H. Fourier, M.D. ADDRESS Glen Burnie, Md. DATE SIGNED 2/4/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Feb. 6, 1954 NAME OF CEMETERY OR CREMATORY Angel Hill LOCATION (City, town, or county) Havre de Grace Harford (State) Md.

DATE REC'D BY LOCAL REGISTRAR 2-4-54 REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR R. Madison Mitchell ADDRESS Havre de Grace, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1234

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 26 (1227)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) SANKEY (Middle) SIDNEY (Last) THOMPSON

4. DATE OF DEATH: (Month) Feb (Day) 19 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: March 12, 1905

9. AGE last birthday: 48 yrs. IF UNDER 1 YEAR Months 2 Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): General Labor

10b. KIND OF BUSINESS OR INDUSTRY: General Construction

11. BIRTHPLACE (State or foreign country): Churchton Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Louis Thompson

14. MOTHER'S MAIDEN NAME: Isabelle Thompson

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 220-16-8193

17. INFORMANT & ADDRESS: Carrie H. Thompson, Churchton Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause (a) Acute Coronary Thrombosis

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Arterial Hypertension Cardio-Vascular Disease — Interval Between Onset And Death: 10 Months

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
None

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1953., to Feb 19, 1954., that I last saw the deceased alive on Feb 18., 1954., and that death occurred at 4:10 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) R. D. Richards M.D. ADDRESS Annapolis Md DATE SIGNED 2/19/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Feb 22 1954

NAME OF CEMETERY OR CREMATORY Franklin

LOCATION (City, town, or county) (State) Churchton Md.

DATE REC'D BY LOCAL REGISTRAR 2/24/54

REGISTRAR'S SIGNATURE Ida Belle Dent

24. FUNERAL DIRECTOR T A Hardesty & Son ADDRESS Galesville Md

VS. A15

RECEIVED
FEB 24 1954
BUREAU V. S.

1235

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct ... especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY ... MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ...
LENGTH OF STAY (in this place) ...
HOSPITAL OR INSTITUTION OR STREET ADDRESS ...

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE ... COUNTY ...
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ...
STREET ADDRESS (If rural, give location) ...

3. NAME OF DECEASED (Type or Print): (First) ... (Middle) ... (Last) ...

4. DATE OF DEATH: (Month) ... (Day) ... (Year) ... 10

5. SEX ...

6. COLOR OR RACE ...

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) ...

8. DATE OF BIRTH 1871

9. AGE last birthday ... yrs. If under 1 year: Months ... Days ... If under 24 hrs.: Hours ... Min. ...

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ...

10b. KIND OF BUSINESS OR INDUSTRY ...

11. BIRTHPLACE (State or foreign country) ...

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME ...

14. MOTHER'S MAIDEN NAME ...

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ...

16. SOCIAL SECURITY NO. ...

17. INFORMANT AND ADDRESS ...

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 4201 (a) ...

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ... (c) ...

INTERVAL BETWEEN ONSET AND DEATH ...

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ...

19a. DATE OF OPERATION ...

19b. MAJOR FINDINGS OF OPERATION ...

20. AUTOPSY? Yes ☐ No ☒

21. INJURY: WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. ☐

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ... (CITY OR TOWN) ... (COUNTY) ... (STATE) ...

TIME OF INJURY (Month) (Day) (Year) (Hour) ... m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR? ...

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐*

SIGNATURE ... (Degree or title) ADDRESS ... DATE SIGNED ...

TYPE OF DISPOSITION (Burial, Cremation, Removal, etc.) Burial

DATE THEREOF 2-17-54

NAME OF CEMETERY OR CREMATORY Brewer Hill

LOCATION (City, town, or county) Annapolis, Md. (State)

DATE REC'D BY LOCAL REG. ~~Feb. 17 1954~~ Feb 20 1954

REGISTRAR'S SIGNATURE ...

24. FUNERAL DIRECTOR William Reese II

ADDRESS 108 W. Washington St. Annapolis, Md.

FEB
BUREAU V. S.

Film#G161 Item# 13 2/15/54 emf

1236

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 1229

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Box 465 Route # I

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Same. COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same
STREET ADDRESS (If rural give location) Same.

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) Ida L. Watts

4. DATE OF DEATH: (Month) (Day) (Year) Feb. 5th 1954

5. SEX: F.
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 6/29/74
9. AGE last birthday: 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unknown Jetter
14. MOTHER'S MAIDEN NAME: ?

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of [redacted]) No
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Albert H. Watts, Severn, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

420.1

Immediate cause (a) Coronary Occlusion ?

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) General Arteriosclerosis 2m.

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from December 53 to Feb. 6, 1954, that I last saw the deceased alive on 2/6/54, 19 , and that death occurred at 7.30 P.M., from the causes and on the date stated above.

SIGNATURE Gustave H. Baucher (Degree or title) ADDRESS Glen Burnie, Md. DATE SIGNED 2/8/54

23. BURIAL, CREMATION, REMOVAL (Specify) burial
DATE THEREOF 2/9/54
NAME OF CEMETERY OR CREMATORY U. S. National Cemetery
LOCATION (City, town, or county) Baltimore, (State) Maryland

DATE REC'D BY LOCAL REGISTRAR 2-8-54
REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR Wm. Cook, Inc., ADDRESS 1217 St. Paul Street

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1237

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (1954)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town: Rural, Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Neck
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Sarah (Middle) (Last) West

4. DATE OF DEATH: (Month) Feb. (Day) 18 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: Mar. 10, 1890

9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR: Months 11 Days 8 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): A. A. Co. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Jane Hall

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Rachel Parker, Annapolis Neck, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

Interval Between Onset And Death: Many months.?

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-15, 1954, to 2-18, 1954, that I last saw the deceased alive on 2-15, 1954, and that death occurred at 2:35 p.m.; from the causes and on the date stated above.

SIGNATURE Faye W. Allen (Degree or title) M.D. ADDRESS 16 Carroll DATE SIGNED 2-21-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Feb 22 1954

NAME OF CEMETERY OR CREMATORY Annapolis Neck

LOCATION (City, town, or county) (State) Annapolis Neck, A.A. Co. Md

DATE REC'D BY LOCAL REGISTRAR Feb. 22, 1954

REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR Annie A. Johnson ADDRESS

FEB
BUREAU V.

1238

01231

MARYLAND — **STATE DEPARTMETT OF HEALTH**

CERTIFICATE OF DEATH

Reg. Dist. No. 28

(M)

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville X
LENGTH OF STAY (in this place): 2 mos. 13 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
STREET ADDRESS (If rural, give location): 1919 Kennedy Avenue ✓

3. NAME OF DECEASED (Type or Print): (First) George (Middle) W. (Last) Whitmore

4. DATE OF DEATH: (Month) 2 (Day) 18 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1874?

9. AGE Last birthday: 80? yrs. — If under 1 year: Months. — Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY: - - -

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk. — (If year, give war or dates of service): Unk.

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

179 X
Immediate cause (a) Generalized Carcinomitosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma of penis

(c)

INTERVAL BETWEEN ONSET AND DEATH: Known to us since adm. 11/5/53

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: - - - -

19b. MAJOR FINDINGS OF OPERATION: - - - - - - - - - - - - - - - - - -

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): - - - - - - -

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): - - - - - - -

(CITY OR TOWN) (COUNTY) (STATE): - - - - - - - - - - - - - - - - - -

TIME OF INJURY (Month) (Day) (Year) (Hour): - - - - - - - m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from 11/5 ..., 19 53, to 2/18 ..., 19 54, that I last saw the deceased alive on 2/18 ..., 19 54, and that death occurred at 8:20 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Sydney Kemper M.D.

ADDRESS: Crownsville, Md.

DATE SIGNED: 2/18/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Feb 20th

NAME OF CEMETERY OR CREMATORY: Mt Calvery

LOCATION (City, town, or county) (State): Arundel Co. Md

DATE REC'D BY LOCAL REG. 2-22-54

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: Edwin O Wilson

ADDRESS

(I)

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

01232

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis 10
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 931 West Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 931 West Street

3. NAME OF DECEASED: (Type or Print) (First) Cora (Middle) Gantt (Last) Williams

4. DATE OF DEATH: (Month) (Day) (Year) February 28, 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Feb. 3, 1869
9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: House wife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Anne Arundel County, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Gantt
14. MOTHER'S MAIDEN NAME: Mary Purdy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ---- (If Yes, give war or dates of service) ----
16. SOCIAL SECURITY No.: ----
17. INFORMANT & ADDRESS: Mr Ernest G. Williams Son Same as # 2

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X
Immediate cause (a) Cerebral Hemorrhage with
DUE TO
Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Rt hemiplegia
DUE TO
(c) Hypertension

Interval Between Onset And Death: 4 days; [illegible]

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis [illegible]

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☑
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 23, 1954, to Feb 28, 1954, that I last saw the deceased alive on Feb 28, 1954, and that death occurred at 8 PM, from the causes and on the date stated above.

SIGNATURE George C. Boril (Degree or title) MD
ADDRESS Annapolis Md
DATE SIGNED 3.2.54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF March 3, 54
NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery
LOCATION (City, town, or county) (State) Annapolis, Maryland
DATE REC'D BY LOCAL REGISTRAR March 2, 1954
REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR Ben L. Hopping and Son
ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The [illegible] age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR
BUREAU

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M

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians; please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01233 26

CERTIFICATE OF DEATH

Reg. Dist. No. 247

Anne Arundel Co.

1. PLACE OF DEATH: COUNTY DRURY, X MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE DRURY, Md COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
CALVIN	NMI	Wilson	Feb	11	1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	NEGRO	widowed		54 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John E. Wilson
14. MOTHER'S MAIDEN NAME: Isabelle Owens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or uokoowo) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Eugene Wilson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
331 Immediate cause	(a) Cerebral Vascular Accident	48 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	10 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Nov, 1948, to 11 Feb, 1954, that I last saw the deceased alive on 10 Feb, 1954, and that death occurred at 8:30 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Robert B Carver	MD	Upper Marlboro Md	Feb 11, 1954

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/14/1954	Moses Cemetery	Drury Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 13, 1954	Catrice Campbell Ida Belle Dent	John T. Stewart	30 N. St. N.E

RECEIVED
FEB 18 1954
BUREAU V. S.

1240

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01234

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY A.A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) X
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS ROCK HILL BEACH PASADENA MD.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD. COUNTY AA
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASADENA
STREET ADDRESS (If rural give location) ROCK HILL BEACH

3. NAME OF DECEASED: (Type or Print) (First) ANNA (Middle) HENRIETTA (Last) YOUNG

4. DATE OF DEATH: (Month) FEB. (Day) 24 (Year) 19 54

5. SEX: F.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH: NOV. 2. 1899

9. AGE Last birthday: 54 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): H. W.

10b. KIND OF BUSINESS OR INDUSTRY: O.H.

11. BIRTHPLACE (State or foreign country): BALTIMORE

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: HENRY C. BOECKER

14. MOTHER'S MAIDEN NAME: SOPHIE BUCHERT.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: MR. CURTIS YOUNG, ROCK HILL BEACH.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) CORONARY THROMBOSIS — Interval Between Onset And Death: IMMEDIATE

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE — 2 YEARS

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JUNE, 1951, to FEB. 24, 1954, that I last saw the deceased alive on FEB 18, 1954, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

SIGNATURE G. Grady Smith (Degree or title) M.D. ADDRESS Riviera Beach, MD. DATE SIGNED 2/24/54

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL DATE THEREOF NAME OF CEMETERY OR CREMATORY MEADOWRIDGE LOCATION (City, town, or county) (State) DORSEY MD.

DATE REC'D BY LOCAL REGISTRAR 2/25/54 REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Henry H. Kirtzke ADDRESS 4101 EDMONDSON AVE.